UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2013
QUALITY IMPROVEMENT INCENTIVE (2)(iv) APPLICATION
Patient Life Enhancing Devices, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2013

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has purchased or enhanced patient life enhancing devices, which must be one or more of the following:
  - ☐ Telecommunication enhancements primarily for patient use. This may include land lines, wireless telephones, voice mail and push to talk devices. Overhead paging, if any, must be reduced.
  - ☐ Wander management systems and patient security enhancement devices (e.g. cameras, access control systems, access doors, etc.)
  - ☐ Computers and game consoles for patient use
  - ☐ Garden enhancements
  - ☐ Furniture enhancements for patients
  - ☐ Wheelchair washers
  - ☐ Automatic doors
  - ☐ Flooring enhancements
  - ☐ Automatic Electronic Defibrillators (AED devices)
  - ☐ Energy efficient windows with a U-factor rating of 0.35 or less
- ☐ A detailed description of the patient life enhancing devices is attached.
- ☐ The patient life enhancing devices were purchased by May 31, 2013.
- ☐ The patient life enhancing devices were installed between July 1, 2011 and May 31, 2013.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to $495 per Medicaid Certified bed under this incentive (count as at 7/1/2012).
This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is $575.80 per Medicaid Certified bed (count as at 7/1/2012).
Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures
Total Reimbursement Requested (should match spreadsheet): $_____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.
Administrator Signature: _____ Date: _____
Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: http://health.utah.gov/medicaid/stplan/longtermcare.htm

For Medicaid use only:		
Amount reimbursed	Maximum per-bed payout:	Date Paid